STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165587	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northbrook Healthcare and Rehabilitation Center	6420 Council Street NE Cedar Rapids, IA 52402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, manufacturer's product manuals, resident and staff interviews, the facility failed to ensure staff utilized the correct full body mechanical lift sling size, resulting in 1 of 3 residents utilizing a mechanical lift to slide in the sling, and be lowered to the floor (Resident #3). The facility identified a census of 79 residents.Findings include:Review of Resident #3's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) Score of 15/15 indicating intact cognition. Resident #3 exhibited upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) functional impairments on both sides of the body and utilized a wheelchair.Resident #3 was not able to do sit to stand (ability to come to a standing position from a sitting in a chair, wheelchair or on the side of the bed) due to medical condition/safety concerns and was dependent upon staff for chair/bed to chair transfers. The MDS listed diagnoses of arthritis, narcolepsy with cataplexy (a chronic neurological disorder characterized by excessive sleepiness and sudden, uncontrolled muscle weakness called cataplexy. Other symptoms include sleep paralysis, hallucinations and disturbed nighttime sleep) and chronic gout. Per the MDS, Resident #3's height was 64 inches (5 foot 3 inches), and resident's weight was 182 pounds.Resident #3's 9/4/25 Nursing admission Screening/History documented, in part, the resident exhibited an unsteady gait and poor balance for motor control, and had a history of falling/recent fall.The 9/5/25 Care Plan listed Resident #3 had an Activities of Daily Living (ADL) Self-Care Performance Deficit related to limited mobility, limited range of motion, and bilateral leg contractures. The Care Plan directed Resident #3 required the use of a full body mechanical (Hoyer style) lift with two staff assistance for transfer and to move resident between surfaces with the full body mechanical lift. The Care Plan lacked direction to the staff on the size or style of sling to utilize with the full body mechanical lift. A Nurses Note dated 10/22/25 at 11:40 AM written by Staff A, Licensed Practical Nurse (LPN) documented the certified nursing assistants (CNA's) were preparing to transfer Resident #3 using a full body lift. The resident slid backwards in the sling and was lowered to the floor with the full body mechanical lift .No injuries were noted. She denied pain or discomfort . Provider notified with no new orders received. An Incident Report dated 10/22/25 at 11:40 AM prepared by Staff A documented a witnessed fall, the CNA's reported that while preparing to transfer the resident using a full body mechanical lift, Resident #3 slid backward in the sling and was lowered to the floor with the full body mechanical lift. The Resident stated, I slid down. The Immediate Action Take Resident #3 was repositioned in the sling on the floor and transferred using the full body mechanical lift to be changed, then was transferred to the wheelchair. The Incident Report lacked documentation of any witnesses or witness statements.An Incident/Interdisciplinary Team (IDT) Note dated 10/23/25 at 6:16 AM, with attendees Staff B, MDS Coordinator, Director of Nursing (DON), Assistant DON and Administrator, documented resident was getting ready for a full body mechanical lift transfer to bed when resident's body began to slid through the middle hole in the sling. The resident was not positioned safely to complete the transfer to the bed and due to the resident's poor position in the sling safe transfer back into the wheelchair was not an option. The resident was lowered to the floor with the assist of the full (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	body mechanical lift and two staff. The sling was repositioned and transfer was completed. The Root Cause of the incident was poor positioning in the full body mechanical lift sling. The IDT note failed to identify Resident #3 was placed in the wrong size sling for the full body mechanical lift.Interview completed on 11/13/25 at 9:39 AM revealed Resident #3 verbalized she had told the staff she wasn't in the lift sling right, but they wouldn't listen to her. They went ahead and transferred her anyway and she slid in the sling and ended up on the floor. Review of Resident #3's EHR Weight Summary record revealed resident's weight was 187 pounds on 11/9/25. On 11/17/25 at 12:05 PM, observation revealed Staff C and D, CNA's positioned a blue purple trimmed full body mechanical lift sling (brand specific sling for a different manufacturer full body mechanical lift #2) under Resident #3. Staff C and D placed the bottom sling straps through Resident #3 legs, crossed the straps between the inner thighs and hooked the sling up the (brand specific #1) full body mechanical lift. Resident #3 leaned to the right once upon in a sitting position in the sling. Staff C and D transferred Resident #3 to the wheelchair. On 11/18/25, review of Resident #3's ADL Self-Care Performance Deficit Care Plan, under Transfers, directed Resident #3 required a full body mechanical lift with two staff assist for transfers, cross lift sling between legs for transfer, revised 11/17/25. On 11/18/25 at 8:06 AM, the ADON explained the CNA staff received education after Resident #3's incident. When the ADON and DON were queried on which full body mechanical lift was utilized for Resident #3's transfer on 10/22/25, neither could answer what actual full body mechanical lift was used that day, but stated they would check with the staff. When queried on which staff members had been involved in the incident, both stated it had been a while ago and they would have to go back and look to see which staff were involved in the incident. The ADON further explained they identified staff had used the type of sling that could have the lower straps crossed between the legs, but the staff had not crossed the bottom straps of the sling between the resident's legs and she started to slide out of the sling. During an interview on 11/18/25 at 8:13 AM the Administrator voiced staff knew the size of sling to use for residents as there was a guide that hung on the lift that indicated the size of sling for the residents to use. When queried when the guides were placed on the lifts, the Administrator did not state a date, but indicated it was after Resident #3's incident. On 11/18/25 at 8:16 AM, Staff B explained each incident report had an IDT note summary in the resident's progress notes where they reviewed falls. The root of the problem was the full body mechanical lift sling when placed did not have the bottom straps of the sling crossed between the resident's legs, which is why she slid in the sling. Staff B didn't know if they had specifically looked at the actual full body mechanical lift as it wasn't a mechanical issue. That was ruled out right away. Staff B didn't know which full body mechanical lift had been used during Resident #3's incident. On 11/18/25 at 8:28 AM, observation of the full body mechanical lift, identified by the DON as the lift that had been used for Resident #3 on the day of the incident, revealed a laminated sling size guide, undated. On 11/18/25 at 9:50 AM, the ADON voiced she had misspoke earlier. The issue with the full body mechanical lift was not crossing the sling under the resident's legs. It was the wrong size sling. When queried on the size used, she stated she couldn't speak to that, but Staff E, Restorative Aide would be the one to talk to about that. Staff E had put out size charts on the lifts after the incident.Interview completed on 11/18/25 at 9:56 AM Staff E, reported he was not present during Resident #3's incident. Through the investigation they concluded the sling was too large for the resident. He thought the blue trimmed sling had been used for Resident #3. Staff E commented the blue trimmed sling was way too big for Resident #3 and the bigger the sling, the bigger the hole in the sling to fall through. Resident #3 was short and she tended to lean forward and roll into a ball in the sling. He voiced he wasn't present during the incident, and didn't know if the sling was crossed between Resident #3's legs. The sling was a toileting sling that was used on her that day. He explained he did the in-service after the incident, demonstrated how to pick the size of the sling, and how to properly place the sling under a resident. The sizing charts went on the lifts after the incident, but he couldn't give an actual date of when he did it. Staff E explained CNAs could determine the size of sling after they got a weight on a resident. They could tell if the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sling was too big for a resident. Staff E voiced he didn't know if the facility had anything in place to communicate size of slings for the staff prior to the incident. They had a 5 Minute Communication Book at each nurse station they looked at every morning that had change of transfer status. He had placed updated sling and full body mechanical lift information in the communication book at each nurses' station (Front A/B Hallways, Back C/D Hallways and CR Hallway). Staff E stated he felt Resident #3 would have been safe even if staff had not crossed the sling straps under the resident's legs if she would have been in the correct size sling. Staff E showed the posted education in the CR unit 5 Minute Meeting Book for Nursing Department Communication Book. He thought he placed the information in the book on 11/10/25, but acknowledged none of the education items were dated when posted in the communication book. During an interview on 11/18/25 at 10:11 AM Staff D explained prior to the incident, there were no guides or tools to follow to determine sling size for the full body mechanical lift. She just eye balled if the sling looked right for the resident. On 11/18/25 at 10:12 AM, Staff F, CNA voiced she just looked at the resident to see if the sling looked right. She didn't know if there were any tools or communication prior to the chart being on the lift. On 11/18/25, review of the 5 Minute Meeting Book for Nursing Department Communication on the Front (Hallway A/B) nurses station revealed an undated posting to use two staff for a full body mechanical lift and standing lift to prevent potential staff and resident injuries and to report any incidents regardless of injury to management as soon as possible. An MDS/Care Plan Communication dated 11/17/25 posted by Staff B regarding the full body mechanical lift and standing lift for nursing directed it was required that two staff assisted with all full body mechanical lift and standing lift transfers. No exceptions. The 5 Minute Meeting Book for Nursing Department Communication (B Hallway) lacked any guide to the staff on the use of the (brand specific) full body mechanical lift. Interview on 11/18/25 at 10:40 AM Staff G, Registered Nurse (RN) reported she was not sure how the staff knew what size of sling to use for the lifts. She wasn't aware of any tools or communication for the aides to determine what to use. During an interview on 11/18/25 at 10:44 AM, the Administrator queried on dates of the undated staff education regarding the lift slings, and stated the education was posted in the books right after the incident, but couldn't give an actual date. On 11/18/25 the DON provided a note that listed Staff H and I were the CNA's involved in Resident #3's incident. Interview completed on 11/18/25 at 12:36 PM Staff A reported the CNA's notified her Resident #3 had slid back in the lift sling and they lowered her to the floor. When she entered the room Resident #3 was laying on the floor to the right of the door of the room. She placed a pillow under Resident #3's head. Resident #3 said she slid backward in the sling, but denied hitting her head, having pain or being injured. She completed vital signs and an assessment on the resident. Staff A explained they transferred Resident #3 from the floor to the bed using the same sling the resident had been lowered to the floor with. She thought the sling did have a hole in the middle of the sling, but didn't remember anything else about the sling. On 11/18/25 at 12:55 PM, Staff H, CNA explained she was not in the room when the incident occurred. It was Staff I and an CNA that Staff I was training. Resident #3 was already on the floor when she entered the room. They positioned Resident #3 back on the same sling she had slid in and lifted her from the floor to the bed with the full body mechanical lift.On 11/18/25 at 1:00 PM, Staff I explained they were lifting Resident #3 with the full body mechanical lift. The issue was the sling was just way too big for her. Part of the issue was the resident refused to have the lift sling left under her in the wheelchair and it was very hard to place the sling under her in the wheelchair with her trunk control and muscle spasms that she had. As soon as she was lifted within 2 inches of coming out of the wheelchair, she was sliding in the lift sling. They couldn't get her safely back to the wheelchair with the way she was positioned in the sling, so they lowered her to the floor for safety. She was assisted by an agency CNA but couldn't recall her name. Staff I voiced prior to the incident they just used the lift slings that were available in the closet. They just picked one and it stayed with the resident until it was soiled or they needed another one. Management didn't direct which type of sling should be used for each resident, but they only had a basic sling and a shower sling they used. She didn't think there was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guide on the full body mechanical lift regarding the size of the slings, but there may have been something in the communication book, but she wasn't sure. During an interview on 11/18/25 at 1:54 PM the DON reported she expected during full body mechanical transfer for two staff to ensure the resident is positioned well and hooked up to the lift correctly. If the staff noticed anything or the resident stated something was not right, she expected staff to acknowledge that as soon as they could. She expected staff to use the guide on the lifts to ensure the residents are in the correct sling size. On 11/19/25 at 9:01 AM, Staff E reported he had put the sling guides on the full body mechanical lifts. The facility has three full body mechanical lifts, two newer ones and an older one. He stated he used the product information from the (brand specific #1) regarding the sling size guide and posted it on each full body mechanical lift. There was a table that stated the size of slings. He stated if looked at brand specific #1 slings and brand specific #2 slings were the same, and one couldn't tell a different unless looked at the label. The slings were interchangeable. The Use of Mechanical Lift Transfers Policy and Procedure, undated, provided by the facility lacked documentation to direct staff on full body mechanical lift sling size or which sling could be used with appropriate lifts. The (brand specific #1) Patient Sling Reference Guide under Patient Sling Guide stated it was very important to use the correct sized sling and make sure it was fitted properly prior to lifting. The Size and Weight Range Guide stated a full risk assessment must be done prior to any sling being selected to ensure the safety for the patient and caregiver. The Brand Specific Full Body Mechanical Lift weight/Height Sling Chart documented a blue large sling for patients weighing 250 to 300 pounds. The (brand specific #2) Patient Sling Reference Guide showed a blue extra-large sling appropriate for patients weighing over 200 pounds to 400 pounds. The (brand specific #2) Battery Powered Patient Lift User Manual under 2.2.6 Lifting the Patient, Warning brand specific #2 sling are made specifically for use with brand specific #2 lifts. For the safety of the patient, do not intermix slings and patient lifts of different manufacturers. The (brand specific #1) Owner's Manual 600 Power Patient Lift provided by the facility on page 6, Warning! Brand Specific #1 medical slings are specifically designed to be used in conjunction with Brand Specific #1 lifts. Do not use slings manufactured by other companies with any Brand Specific #1 medical equipment. Using other manufacturer's slings on equipment is unsafe and may result in serious injury to users and caregivers. Page 19 Transfer from Wheelchair directed to draw the legs sections of the sling to the front along the length of the user's thigh and feed the legs sections under the thighs. From between the legs, gently pull the leg section up the inner thigh. Feed as much material as possible under and between the thighs. Ensure the leg sections are positioned midway under the thighs to provide good support and greater comfort. Attach loops to the lift. Lift patient above the wheelchair. Pull the lift away from the wheelchair and position the patient over the bed and lower patient onto it.